Adult Mental Health Block Grant FY 2006 - 2007

CRITERION 1: Comprehensive Community-Based Mental Health Service Systems

Montana is a geographical large state but has a population of less than one million. Many people have been working in the mental health field for twenty or more years. Relationships have been forged and partnerships have been developed. The dedication and resourcefulness of Montana's providers is a resource that will ensure Montana continues moving in transformation of its mental health service system. This transformation will bring service provision more directly in alignment with the New Freedom Commission directives in providing consumer driven care.

The Addictive and Mental Disorders Division has taken the New Freedom Commission Report to heart. Given this direction, the mental health system in Montana has begun evolving and developing the necessary tools for a recovery and consumer centered system. Montana has a long journey ahead but with the cooperation of the stakeholders, providers, consumers and family members; transformation effort of the public mental health system will succeed.

The journey for the next two years will include continued focus on the following areas: strength-based case management, co-occurring initiative, evidence based and promising practices, supported employment, peer support services, Service Area Authorities, crisis services, HIFA and Home and Community Based (HCBS) waivers, housing, and regional staffing to name only a few.

Mental Health Services

Montana State Hospital (MSH) is the only public inpatient psychiatric hospital in the state. The hospital provides short-term emergency care as well as extended treatment for adults with serious and disabling mental illnesses. Patients are admitted from across the entire state of Montana, often following a short stay in a psychiatric unit in a community hospital. State law governs admissions to the hospital. In FY 2005, 63% of the population was civilly committed, 12% were guilty but mentally ill, 9% were unfit to proceed, and 12% were not guilty by reason of mental illness. Patients on forensic commitments generally have much longer stays than those on civil commitments.

Treatment at MSH is focused on symptom stabilization and resolving problems that led to hospitalization. Treatment is organized in a clinical pathway model called "Pathways to Recovery", designed to guide people through stages leading to greater independence. Approximately 60% of the patient population is scheduled to be involved in one or more educational or group or individual therapy programs. All of these programs use the Dialectical Behavioral Therapy (DBT) model to some extent. About 40% of the patient population at any one time is involved in one or more chemical dependency treatment programs. These include group and individual therapies, twelve step programs, educational programs, and motivational enhancement. Both co-occurring and DBT are major areas of emphasis in the treatment

programs along with programs that place emphasis on skill development and understanding illnesses. The five major pathways offered are:

- Coping Skills – emphasis is on learning self-management of emotional reactions to life's events through the use of Dialectical Behavioral Therapy (DBT) skills.
- Co-Occurring – emphasis in on treatment of substance use and abuse along with co-occurring symptoms of psychiatric illnesses.
- Social and independent living skills – emphasis is on using a psychiatric rehabilitation approach to teach skills needed for independent living in the community.
- Adaptive Living Skills – emphasis is on a highly individualized program of care with adaptations for independent needs.
- Management of Legal Issues – emphasis is on understanding legal status and procedures in order to regain fitness to proceed and understand legal consequences of actions.

Combined with the stages of change model, the Pathways for Recovery model looks like this: (sample)

	Coping Skills	Co-Occurring Treatment	Social and Independent Living Skills	Adaptive Living Skills	Management of Legal Issues
Orientation					
Pre-Contemplation					
Contemplation					
Preparation					
Action					
Maintenance and Relapse Prevention					

The hospital works closely with the adult care coordinators and licensed mental health providers across the state to coordinate care and to return individuals to their home communities for appropriate aftercare services.

The MSH has 369.8 employees and had a budget of $23,349,659 for FY 2005. The hospital has 8 psychiatrists, 2 physicians, 1 physician assistant, 1 APRN (beginning September 2005), 6 licensed psychologists, 3.5 MSW, 13 BA or unlicensed social workers, 5 unlicensed/certified personnel also in therapist positions (1 currently filled), 2.75 licensed substance abuse therapists, 4 certified teachers, 30.4 registered nurses (8.5 currently vacant), and 27 LPNs (8 currently vacant). The nursing shortage is at the crisis point. The MSH has requested pay exemption for the nursing positions to recruit.

The facility was built for 135 patients, budgeted for 175 and licensed for 189 patients. The average daily census for FY 2005 was 185. In August 2005, the census jumped dramatically. The communities were asked to actively pursue other options in the community prior to admission to the state hospital.

Montana Nursing Care Center (NCC) is the only state operated nursing care facility for individuals with mental disorders. The Center provides long-term care and treatment to people who require a level of care not available in communities or will not benefit from intensive psychiatric treatment. The NCC has 122.7 employees, licensed for 191 patients, have 100 beds available and has an average daily census of 75. In FY 2004 money was allocated from the NCC budget to the community mental health budget to place residents into community residential settings. This has proven to be very successful with only one resident being returned to NCC. Residents have been placed in Great Falls, Billings, Butte, and Glendive.

Montana's mental health services are provided by a variety of local agencies including licensed mental health centers, independent private practitioners, and short-term psychiatric inpatient units in community hospitals. The community psychiatric inpatient units are located in Kalispell, Missoula, Billings, Glendive and Great Falls. Five community mental health centers provide the majority of services. Four of the five agencies serve a multi-county region and each participating county appoints one commissioner to the center's governing board. Each governing board includes a primary consumer, a family member of a consumer, either a parent or a child with an emotional disturbance, and either a person representing the interests of the elderly or a health care professional. AWARE, the fifth provider has offices state wide but there adult services are primarily located in Glendive, Butte, Bozeman, Great Falls, and Missoula.

The five licensed mental health center providers are as follows:

Eastern Montana Community Mental Health Center (EMCMHC) serves seventeen counties in the eastern-most part of the state. This is a huge land area (47,747 square miles) with a population density of 2 people per square mile. The largest communities in this region have populations between 4800 and 8700 people.

EMCMHC offers some level of services in all seventeen counties, although some communities are served on a part-time basis by staff traveling from offices in other counties. Targeted case management for adults is available throughout the entire service delivery area. Day treatment services for adults with severe mental illness are provided in Miles City, Glendive, and Sidney. A residential program (an adult group home and adult foster care) is located in Miles City.

One psychiatrist maintains a practice in the eastern region at the Glendive Medical Center. The nearest alternative acute hospital care is in Billings or in hospitals located in North Dakota. Primary care physicians, advanced nurse practitioners, and interactive video provide medical management for the consumers in this region.

The shortage of psychiatric resources creates the most notable service gap within the region. To address this, the region has well-established interactive video capability, enabling center staff and consumers to have live audio and video contact with staff at Deaconess Billings Clinic. There are currently seven locations where this capability exists.

Golden Triangle Community Mental Health Center (GTCMHC) serves a twelve-county area in north central and southwest Montana. The two largest communities in the region are Great Falls (population 56,690) and Helena (population 25,780). Both have well-developed

community support systems under the leadership of GTCMHC including a well-coordinated program of day treatment, targeted case management, outpatient psychotherapy, medication management, supported employment, transitional and residential living (group home, semi-independent living, adult foster care), and Assertive Community Treatment (ACT) services. Psychiatrists employed by GTCMHC admit patients to the psychiatric unit at Benefis Medical Center in Great Falls. The psychiatric support center at St. Peter's Hospital in Helena has remained closed since 2001 due to the difficulty recruiting and retaining staff psychiatrists.

GTCMHC provides psychotherapy in ten of the twelve counties of the region and targeted case management in all twelve counties. Day treatment is offered in four counties including a program on the Blackfeet Indian Reservation in Browning. Medication review in the smaller satellite offices is on a consulting basis by psychiatrists based in Great Falls and Helena.

South Central Montana Regional Mental Health Center (MHC) is located in south-central Montana and includes Billings, Montana's largest city with a population of about 89,850. The region encompasses a total of twelve counties.

The Mental Health Center provides comprehensive services in Billings including psychiatry, psychotherapy, day treatment, adult residential services, assertive community treatment, intensive case management, and drop-in services. The center has a cooperative relationship with vocational rehabilitation providers, allowing for a range of vocational service options. The center also works collaboratively with the Montana Department of Corrections and Department of Veterans Affairs. Two major community resources are the Billings Deaconess Hospital, which has the state's largest psychiatric unit for short-term inpatient acute care and Rimrock Foundation, which provides crisis stabilization services and is also a state approved alcohol and drug provider.

The Mental Health Center provides psychotherapy services in other communities in the Region. In cooperation with Billings Deaconess Clinic, Deering Clinic (public health center), and St. Vincent Hospital the providers have purchased a facility for crisis stabilization. The center will be opening in the fall of 2005. This is the culmination of over five years of collaboration.

Western Montana Community Mental Health Center (WMCMHC) serves fifteen counties in western and southwestern Montana. The area is the most populated region of the state with a density of more than ten people per square mile. Missoula is the largest western city with a population of 57,050. WMCMHC has worked to provide a comprehensive service system in Missoula, Butte, and Kalispell. Each of these communities has psychotherapy, day treatment, targeted case management, psychiatric services, mobile crisis and crisis residential services. Kalispell Regional Hospital and St. Patrick Hospital in Missoula each have inpatient psychiatric services. WMCMHC provides psychotherapy, adult foster and group care, and case management services in the other twelve counties in the region. Missoula and Kalispell have Assertive Community Treatment (ACT) services. WMCMHC also provides medication monitoring to outlying communities by psychiatrists who travel from Missoula, Bozeman, and Kalispell.

Despite a well developed range of services provided by the mental health center and the availability of substantial community resources in Missoula, the rate of admissions to Montana State Hospital is high, indicating the need for further community support system development, particularly crisis response.

A.W.A.R.E. provides limited services to adults with serious mental illness, including targeted case management, intensive community-based rehabilitation, and adult residential services. Services are provided in Bozeman, Missoula, Butte, Great Falls, and Glendive.

Co-Occurring Initiative

Addictive and Mental Disorders Division has continued to contract with Dr. Ken Minkoff and Dr. Chris Cline to provide technical assistance in moving the substance abuse and mental health services towards a more comprehensive and coordinated service array and integration of services to the estimated 40% of SDMI adults with co-occurring issues. Nineteen programs have completed the Co Morbidity Program Audit and Self-Survey (COMPASS) and of those programs thirteen have developed action plans for moving towards comprehensive and coordinated services to address concerns and more appropriately serve this population. AMDD completed the Fidelity and Implementation Tool (CO-FIT) and has developed an action plan for the next three years to move the mental health and chemical dependency systems by: Identifying, designing, and managing a data system that supports implementation of co-occurring; Developing decision-making, advisory, and support structures; and developing the capability to provide integrated treatment for persons with co-occurring disorders within existing service delivery system. The executive committee and co-occurring strategy team have finalized the one-year plan for AMDD. The one-year plan focuses on: screening tools, welcoming policy, clinical standards, marketing plan, quality improvement, policy academy, and appropriate training. A team formed by AMDD will be attending the Policy Academy for Co-Occurring Disorders in September. We foresee this is an opportunity will bring the co-occurring initiative to the governor level. We have identified trainer of trainers for each agency and will continue to have a minimum of quarterly trainings. The trainers will train their individual agencies and help create a seamless delivery system for individuals with co-occurring needs.

The goals of the AMDD and trainers will be to develop performance measures for the mental health and addiction systems, identify screening tools for the substance abuse and mental health agencies, welcoming policies, and defining ”co-occurring capable” and “co-occurring enhanced” as it pertains to Montana programs. This initiative has been accomplished by pooling our resources with no additional funding.

The Montana State Hospital has developed a co-occurring clinical pathway; designed to more effectively serve those patients identified as having a mental illness as well as chemical dependency. The Montana Chemical Dependency Center (MCDC) has a co-occurring track as well. MCDC has a psychiatric social worker and licensed addiction counselor identified as the team supervisors. MCDC contracts with a psychiatrist for consultation and medication monitoring. These two programs have proven to be beneficial to the patients in hastening appropriate treatment. Rather than postponing one form of treatment both disorders are addressed at the same time.

Employment, Rehabilitation and Educational Services

Each of the mental health centers either have a vocational person on staff or have an agreement with the local vocational rehabilitation office. These persons identify what the client is most interested in pursuing and matching those interests with the person's capabilities. This includes both education and vocational services. Many persons complete their GEDs and some consumers have gone on to take college classes and obtain degrees. The centers have supportive employment as well as some competitive placements.

AMDD has had standing cooperative agreements at the state level with the Montana Vocational Rehabilitation (MVR) Services Programs that outline their commitment to both supported and transitional employment programs since the inception of supported employment in Montana. While these agreements have served to define terms of service, and provide general guidance regarding the execution of employment services, both AMDD and MVR are committed to strengthening these relationships and increasing the incidence of successful, meaningful employment outcomes for persons with mental illness. To that end the agencies will strengthen service provision in Montana by providing technical assistance to local service communities for the purpose of developing local Cooperative Agreements that reflect a commitment to building stable, sustainable return to work programs utilizing the coordinated assets of AMDD and MVR.

The AMDD and the MVR are working cooperatively to provide training to both the vocational rehabilitation counselors and the mental health centers on creating better employment outcomes using strengths based as the foundation. The training will be provided in Billings in September. The employment specialist from Western Montana Mental Health Center and the Strengths Based Case Manager trainer from Colorado will be the trainers. The trainer from Colorado previously provided training to the mental health center case managers and supervisors. This will be a bonus to the training, as the mental health system will continue building on the skills already learned. The goal or expected outcome of this cooperative endeavor will be developing better working relationships and plans to better collaborate with traditional community services for the benefit of the consumer.

The Department has applied to the Department of Labor for a grant to develop the infrastructure within the Department to allow persons to work and keep Medicaid. Fear of losing Medicaid is the number one fear of persons returning to work. The grant was submitted in July and we should hear about the grant by the end of September.

Transformation of Mental Health Services

Montana has provided intensive training in Dialectical Behavior Therapy (DBT) the last two years. Currently, we have nine mental health programs, three chemical dependency programs, two hospitals, three youth programs, and one team at the men's state prison, and one private practitioner team trained in Montana. This translates to 134 intensively trained individuals. In May, AMDD provided the two-day DBT-Substance Abuse training to 140 individuals.

The DBT Steering Committee will be developing outcome measures and ongoing training plans for the next two years. Both the Montana State Hospital and Montana Chemical Dependency Center have trained teams. This is a service provision, which has proven effective in serving individuals who are traditionally consumers of high costly mental health services as well as emergency services.

Assertive Community Treatment (ACT) teams have expanded from Helena and Billings to include teams in Great Falls, Kalispell, and Missoula. The teams include an addiction specialist on the team. These programs have been given expanded funding to include non-Medicaid consumers. This has been a major issue in getting persons served by an ACT Team. Many of the participants were not Medicaid eligible and the mental health centers found themselves providing the service without reimbursement or not being able to provide the appropriate services. The 2005 Legislative Session provided general funds for non-Medicaid population. This service has proven to be successful in keeping persons in the community rather than at the state hospital or in non-independent residential placements and reducing the days of inpatient hospital care.

Montana is probably the last state in the union to have a plan to provide peer support services on a statewide basis. There are mental health centers that employ consumers in supportive employment. This has been done on a case-by-case basis. To further our recovery initiative it is important that peer services be developed in a much more comprehensive fashion rather than hit and miss. The Mental Health Oversight Advisory Council (MHOAC) is including peer services as one of their three goals for the year. MHOAC consists of over 50% consumer and family members, which make the council uniquely qualified to research, direct, and assist in the development of consumer driven services. The Council has requested technical assistance of various models on peer services for their November 2005 meeting.

We are in the infancy stages of developing this service and a plan will be developed over the next six to nine months to implement this evidence based practice in Montana. The plan will include, but not be limited to the following: the development of policies and procedures, reimbursement for peer specialists, job descriptions, definition of peer services, and consumer empowerment. With the support of consumers, family members, stakeholders, providers, Council members and mental health staff, comprehensive peer services will become a reality in Montana.

Montana is continuing to develop Service Area Authorities (SAA). We have designated three SAAs. They are the Eastern, Western and the Central Service Area Authorities. All three SAAs have incorporated and have registered with the Secretary of State. The boards are required to have 51% consumer and family member representation. Boards are prohibited from having providers as board members. The SAAs will be providing guidance to the AMDD for services. The SAA will steer the system with the assistance from the Local Advisory Councils (LAC). AMDD will provide the financial and technical support.

The first project will be the development of a plan for a crisis response system that the Division can present to the 2007 Legislature. The Division is also planning to provide $80,000 in block grant funds to each of the SAAs in FY 2007. The SAAs will have authority to spend these funds

once they assess priorities and determine what needs to be funded in each of their service areas. This important as the leadership of each SAA has an awareness of the unique strengths and concerns that exist within each of their jurisdictions.

Strengths Based Case Management

AMDD received technical assistance through the Olmstead contractor for case management training earlier this year. In the past attempts to bring this model to the state were unsuccessful for a number of reasons. In the 1980's, the mental health centers received strengths-base training on strengths based case management. The follow up with the mental health centers never happened as the Division move to another priority. In 1998, the managed care company provided training on Role Recovery. Providing services in a Role Recovery model lost momentum when the managed care company began having serious administrative and financial concerns. Each time the training was provided and then the model dropped off of the radar screen. In providing this training on strengths based case management, we assured the mental health and substance abuse providers that we would include follow up and indeed this would not be another "wasted" training. AMDD is committed to a system of ongoing support and training.

AMDD supported training of 142 case managers in May and was accomplished through technical assistance from Advancement for Human Potential and contracted with the University of Kansas to provide the training. Two teams provided the training in four different locations. The teams consisted of the mental health supervisor from University of Kansas, an addiction counselor and a consumer. The teams provided two-day case manager training in Butte, Great Falls, Billings, and Missoula. The last day of the week the supervisors were trained on how to use the model and build Montana provider capacity to provide supervision in strength's based case management model.

The programs will be providing outcome measurement information for each of their case management clients through an Internet based system and collected quarterly. This data will prove useful in identifying ongoing needs, both for consumers and for providers. The measures that we have chosen are housing, employment (including education), level of symptom interference, alcohol and/or drug stages of change and level of use. We will have conference calls in October with the supervisors and the University of Kansas consultants to help answer any questions and reinforce the group supervision techniques. AMDD will identify a core group from case managers and supervisors to become the trainers in strengths based case management in November 2005. This core group will receive intensive training on presenting the model. This will develop our capacity of trainers for Montana rather than contracting with trainers from University of Kansas every time training is needed. Also we will be working with the University of Kansas as they develop DVD training modules. We will be providing each of these to our programs for training of new case managers.

Activities to Reduce Hospitalization

Montana is unique from other states in the access to the state hospital. The Montana State Hospital does not have a "gatekeeper" for admissions to the hospital. The hospital is licensed for 189 beds. Many times the patient census has gone over the 189. The Division contracts with

First Health Services to provide two adult care coordinators. These care coordinators work closely with the hospital to ensure more successful community placements. These coordinators are familiar with the community resources available across the state and work cooperatively with community providers to creatively wrap those services around persons discharged from the state hospital to help ensure they are appropriately supported as they transition to community levels of care.

The Department has attempted numerous times to get a preadmission screening bill passed in the state legislature. These measures have failed miserably each time. In the 2003 Legislative session Behavioral Health Facilities development was funded. However, the Department could not get anyone to bid on the request for proposals. The biggest difficulty is the medical liability the community hospitals are not willing to risk. The 2005 Legislative session passed a senate resolution to study the possibility of community crisis plans and what those would entail. The Division is also required to present a plan for crisis services to the Interim Committee and the 2007 Legislative Session.

The Council on Homelessness received approval to participate in the Policy Academy on SSI/SSDI Documentation training. Two persons will be sent in December to receive intensive training from Yvonne Perrette, a nationally recognized expert. These persons will provide the training in Montana for better documentation for the SSI/SSDI applications. In addition, up to thirty persons will receive two-day training and plan development from the academy in mid December.

The regional administrator for the Social Security Office in Denver has arranged for Montana to send five persons to the training provided by Yvonne Perrette. The persons attending in August will be case management supervisors and the eligibility specialist from the state hospital. The four individuals will provide training to the PATH case managers at the quarterly meetings. The eligibility specialist will train the administration at the state hospital. After the Academy, a plan will be developed to expand this training and provide technical assistance to the state hospital and the case managers. In addition, the regional office has funds to ensure follow up with the five persons attending the Denver training.

This is the next step after the training AMDD and the Disability Determination Services have done the last eighteen months. We have trained over 100 persons on SSI 101 and the importance of documentation. We also provided more intensive documentation training to case manager supervisors and PATH case managers in the fall of 2004. We have been chipping away at this crucial stumbling block for consumers to obtain benefits and be able to live in the community.

The Department created the Intensive Community Based Psychiatric Rehabilitation for those persons that have been hospitalized and have had repeated community failures. These persons are usually seriously mentally ill and have other complications such as physical disability. 34 persons have been placed in the community from the Montana Nursing Care Center or Montana State Hospital. The homes are in Great Falls, Missoula, Billings, Butte and Glendive.

The 2005 Legislative session authorized the Department to apply for the Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver. The proposal will be sent into CMS in

September. It is anticipated that once approved, the Department can implement the waiver in FY 2007. The proposal would secure Medicaid financing for a portion of the state-funded Mental Health Services Plan (MHSP) that currently provides mental health services and pharmacy benefits to approximately 2,200 people per month who have a severe disabling mental illness but are not eligible for Medicaid. The waiver would enhance the quantity, quality and range of services available to the persons with severe disabling mental illness. The service improvements would include: $1.3 million per year in additional funding for the existing Mental Health Services Plan; a physical healthcare benefit for approximately 1500 MHSP recipients a month, who currently do not have health care coverage; $200,000 per year in Medicaid funding for short term in-patient acute psychiatric benefit; and $240,000 of community block grant to address other system of care issues. Under the waiver, the beneficiaries will have the ability to choose the physical health care benefit that best meets their needs.

Finally, the Department has been authorized to develop a Home and Community Based (HCB) Waiver. The waiver will provide community services to those persons with severe mental illness and other disabling conditions who other wise are in a nursing home. It is anticipated the waiver will be submitted to CMS in FY 2006.

Medical and Dental needs

Each community mental health provider ensures that medical and dental needs are addressed for each client served by the mental health system. Those persons with Medicaid are easily served for their medical needs. However, dental care continues to be an ongoing problem for all persons with Medicaid. Persons with MHSP are served through public health clinics and federally qualified clinics that provide medically necessary services for physical and dental health. Medications have been accessed through the federally qualified clinics.

Housing Services

The Western Montana Mental Health Center has a full time housing developer. This person has been of staff since the early 90s. The center has numerous housing options available in the Missoula area. They include: Single Room Occupancy apartments, apartments, group homes, detoxification unit, half way house for co-occurring, housing units for women and children, and condominiums available for home ownership. The housing specialist has assisted other communities such as Butte, Hamilton, and Kalispell in obtaining housing options.

The South Central Mental Health Center in Billings has group homes with onsite supervision and one house that do not have supervision on site. The center has good relationships with the housing authority and landlords.

AWARE, Inc. has a fulltime housing developer. They have group homes available in Butte, Glendive and Great Falls. The housing has followed the universal design and appears as a duplex with common community areas.

All of the community mental health centers utilize shelter plus care vouchers. This program is very successful in Montana. The communities of Billings, Missoula, Helena, and Butte have access to these vouchers.

The State Continuum of Care has applied for fourteen Shelter Plus Care vouchers through the Department of Commerce, Housing Division. This is the first ever-joint effort by the two Departments. These vouchers, if funded, will be provided directly to PATH programs in Kalispell, Great Falls and Billings to manage. Kalispell and Great Falls have never had shelter plus care vouchers. The Billings PATH program will train the two other programs. AMDD and the Housing Division will be developing the program prior to implementation.

The PATH program applied for technical assistance to develop housing plans for the major communities in Montana. The communities that are receiving technical assistance are Great Falls, Billings, and Helena. Each of these communities is in different stages of organization and planning. Billings would like to create a Safe Haven. They have invited a banker, housing developer, city personnel, public housing authority, and shelter managers to the table to pursue this concept. Great Falls will be meeting with the Human Resources Development Council (HRDC) to develop a collaborative housing project. The Helena community will be approaching the Hunger and Homeless Coalition for collaboration on a project. They researching the development a Single Room Occupancy (SRO) and a crisis stabilization facility. Ann Denton and Margaret Lassiter have provided the two-day training and the ongoing consultation with each community.

The AMDD is an active member of the Governor's Council on Homelessness and is represented on the Council itself. In addition, Division staff members are serving on workgroups addressing housing, special needs population, and access to and delivery of mainstream services.

The Department received a CMS Real Choice Grant in FY 2003 that had three prongs including housing, transportation and advocate training. The Division's portion of the grant was the housing. The grant created the Home CHOICE Coalition where the developers, bankers, providers of services, HUD, Fannie Mae, realtors, and consumers collaborated to develop housing opportunities for persons with disabilities. This is the final year of the grant; to date over 8 persons or families have purchased their own homes that likely would have been unable to do so without these efforts. In addition to these activities, all stakeholders have been made aware of the opportunities available to their beneficiaries through ongoing education. The Coalition has provided group homes in Butte and Glendive that have universal design (handicapped accessible) and are available to persons being discharged from the state hospital or nursing care center. This is a wonderful opportunity to facilitate home ownership for a segment of the population that might not otherwise have the opportunity. The Department submitted another grant application in July. This grant will center on continuation of the projects invested in under the initial grant and build upon these efforts by creating a housing registry.

Corrections and Mental Health

The Departments of Corrections and Public Health and Human Services Human Resources have a signed Memorandum of Understanding to improve access to federal benefits for those with

serious mental illnesses leaving the prison. The MOU resulted from several meetings of staff from both agencies who identified some of the problems faced by mentally ill prisoners re-entering the community. One outcome of these discussions is that individuals in pre-release programs are now eligible for Medicaid or MHSP and have coverage for medication and other mental health services. In addition, the Department of Corrections created several "special needs" slots in pre-release programs for disabled individuals who cannot meet the usual work expectations.

Recently, the Department of Corrections and the Department of Public Health and Human Services have proposed the new position of Mental Health Liaison, to be located in the Department of Corrections but attached to the Department of Public Health and Human Services. The position will be dedicated to improving communication, cooperation, and collaboration between the two departments as they rise to the challenge of serving seriously mentally ill people involved in the criminal justice system. The position will focus on improving transitions and placements as offenders leave correctional institutions. The liaison will support diversion programs designed to appropriately manage and place seriously mentally ill individuals outside of the correctional institutions when possible. The position will attempt to develop more community resources for this population. It is expected the position will be funded mid FY 2006.

The Mental Health Oversight Advisory identified "improved access to mental health treatment for mentally ill prisoners" as one of its top three priorities. This area was identified in part due to the fact that the forensic population is the fastest growing population at the state hospital. The Council will focus primarily on those returning to communities in need of mental health treatment, although there is also some interest in diversion activities and mental health courts.

Goal One: To significantly increase consumer participation and satisfaction in community mental health services.

Indicator One:	**Increase the percentage by 4% each year of those adults with SDMI that report involvement in their treatment planning.**
Measure:	Numerator: The number of respondents who answered "Agree" or "Strongly Agree" to three survey questions that relate to involvement of the respondent in treatment planning. Denominator: The total number of adult respondents to the Consumer Satisfaction Survey.
Source of Information:	Statewide aggregate data from the Consumer Satisfaction Survey.
Significance:	Allowing the consumer a role in mental health care allows for choices and greater responsibility for one's care. Taking on that responsibility increases feelings of self-esteem, self worth, dignity and self-respect. Data reported is based on consumers' self reports.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	64%	65%	69%	73%	77%
Numerator	373	262	280	296	313
Denominator	580	406	406	406	406

Indicator Two: **Increase the percentage by 4% of those adults with severe mental illness that report positively about their outcomes with mental health services.**

Measure: Numerator: The number of respondents who answered "Agree" or "Strongly Agree" to three survey questions relating to access.
Denominator: The number of respondents to the survey.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Allowing the consumer to participate in choices and have greater responsibility for their care moves the consumer to recovery and positive outcomes. Taking on that responsibility increases feelings of self-esteem, self worth, dignity and self-respect. Data reported is based on consumers' self reports.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	64%	61%	65%	69%	73%
Numerator	373	249	265	281	297
Denominator	580	407	407	407	407

Indicator Three: **Increase the percentage by 4% each year of adults with serious disabling mental illness that rate the access to services positively.**

Measure: Numerator: The number of respondents who answered "Agree" or "Strongly Agree", to three survey questions relating to access, on a five point response.
Denominator: The total number of adult respondents to the Consumer Satisfaction Survey.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Quick, convenient entry into the mental health system is critical in accessibility of services. The data reported is based on consumers' self report.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	81%	81%	85%	89%	93%
Numerator	472	330	347	363	379
Denominator	580	408	408	408	408

Indicator Four: **Develop at least one peer service in each of the mental health provider agencies by FY 2007.**

Measure: The number of programs providing or operating peer support services.

Source of Information: The number of services provided.

Significance: The community mental health providers have not used peer support services in any organized fashion. Montana needs to develop definitions, policies of the use of peer services and reimbursement structure for those services. This would provide additional capacity for community services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	0	0	0	>1	5

Goal Two: To provide quality community mental health services.

Indicator One: **Increase the number of evidence based practices provided by the state.**

Measure: The number of evidence-based practices available in the community mental health centers and Montana State Hospital.

Source of Information: Number of practices provided reimbursement.

Significance: These practices and proven outcomes move the individual with mental illness towards recovery.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	2	2	>2	>2	>2

Indicator Two: **Increase the number of persons served through Assertive Community Treatment (ACT) programs.**

Measure: The average number of persons served.

Source of Information: Reports from ACT programs.

Significance: The ACT program has proven to be effective in keeping persons with chronic mental illness in the community and with fewer hospitalizations.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	165	168	276	300	350

Indicator Three: **Develop signed work/employment service agreements between MVR local authority and the local community mental health providers.**

Measure: The number of signed service agreements.

Source of Information: Copies of the signed service agreements sent to office.

Significance: Employment is key to recovery and person centered treatment.

(1)	(2)	(3)	(4)
Fiscal Year	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Signed Agreements	0	2	4

Goal Three: **Comprehensive, accessible, community-based mental health services will be available to adults with severe disabling mental illness.**

Indicator One: **Continue developing integrated co-occurring services.**

Measure: Numerator: The number of providers using Ziologic Tools for assessment of co-occurring capable (COMPASS).

Denominator: Total number of providers to whom the tools were made available.

Source of Information: Report from the Division.

Significance: It is estimated that at a minimum 40% of the consumers have a dependence or abuse problem in addition to mental illness. Addressing these issues in an integrated manner provides more effective treatment.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Numerator	0	0	19	21	25
Denominator	28	28	28	28	28

Indicator Two: **Collect outcome measures for Assertive Community Treatment (ACT).**

Measure: Increase the target for education and employment outcomes by 50% in FY 2006 and increase in FY 2007.

Numerator: Average number of clients working or attending education per month while receiving ACT services.

Significance: The outcomes tracked will provide evidence of the successfulness of the program.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Competitive Work	14	12	> 14	21	>21
Non-Competitive Work	12	8	>12	18	>18
Volunteer Work	8	7	> 8	12	>12
Education & Training	5	3.5	> 5	7.5	>7.5

Indicator Three: **Continue Dialectic Behavioral Therapy (DBT) programs in community, Montana Chemical Dependency Center (MCDC) and MSH.**

Measure: a) The number of programs providing DBT.
b) The number of beneficiaries participating in DBT.

Source of Information: a) Report from DBT work group.
b) Authorizations and paid claims data.

Significance: This therapy is a promising practice for many persons that have been very difficult to maintain in the community setting.

a)	(1)	(2)	(3)	(4)	(5)	(6)
	Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
	Performance Indicator	3	19	19	20	20

b)	(1)	(2)	(3)	(4)	(5)	(6)
	Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
	Performance Indicator	25	29	55	>60	>60

The figures above are for Medicaid clients in the community mental health system only. They do not include chemical dependency, Montana Chemical Dependency Center (MCDC) or Montana State Hospital (MSH) figures.

Goal Four: Adults with Severe Disabling Mental Illness will be discharged from the Montana State Hospital in a timely and appropriate manner to the community.

Indicator One: **Decrease the number of persons discharged from the Montana State Hospital who are readmitted within 30 days of discharge each year.**

Measure: Numerator: Number of adults readmitted to the MSH within 30 days.
Denominator: Total number of MSH discharges.

Source of Information: Admission/discharge data from MSH.

Significance: Rapid recidivism may reflect ineffective community programs, very serious illness, premature discharge, or noncompliance.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	N/a	7.87%	7.5%	7%	6.5%

Numerator	N/a	508	N/A	N/A	N/A

The data collected in FY 2003 was different than how FY 2004 – 2007 is calculated.

Indicator Two: **Decrease the median length of stay for discharged patients to 55 days (5%). The current median length of stay is 58 days.**

Measure: Calculation of the median length of stay for MSH.

Source of Information: MSH admission and discharge data.

Significance: Shorter lengths of stay are measures of effective efforts to develop and expand community services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	58	58	55	<55	<55

Goal Five: **To provide case management services to those persons with serious and disabling mental illness who need and want this assistance.**

Indicator One: Continue the availability of those persons who want and need case management.

Measure: The number of persons receiving case management.

Source of Information: The reimbursement data.

Significance: Case management provides the necessary linkage and referral for community integration as well as diversion from hospitalization.

Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
# Persons receiving case management	N/a	6178	5646	5900	6200

The FY 2003 case management figures are not applicable. During FY 2003 the Department paid for care coordination, part time case management and full month case Management. The Department has been actively educating the case management on What is case management and what is psychiatric rehabilitation.

Indicator One: **Train case managers and case manager supervisors in Strengths Based Case Management.**

Measure: Number of case managers and supervisors trained in case management.

Source of Information: The attendance sheets for the trainings.

Significance: The training and follow up with supervisors will enable the state to move closer to recovery and person centered planning.

Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
# Case managers trained	N/A	N/A	142	>142	>142
# Supervisors trained	N/A	N/A	50	>50	>50

CRITERION 2: Mental Health System Data Epidemiology

Incidence and prevalence

The number of adults with serious mental illness in Montana is estimated to be 34,951. This number is based on the number of adults in 2000 census data and application of a methodology developed by CMHS (5.2%). According to the FY 2004 data a total of 15,519 were served. This translates to a 44% penetration rate.

The State of Montana uses the definition of Severe Disabling Mental Illness (SDMI). All estimations of adults with mental illness are based on either the severe and persistent mental illness (SPMI) or serious mental illness (SMI). Montana needs to have a true estimate of those persons with SDMI, in order to adequately fund and design services for this population. The Division will be contracting with WICHE in Colorado to calculate an estimate of the SDMI population in Montana. It is hoped by the end of FY 2006 we will have a better estimate of the population the public mental health system needs to serve.

Definition of Severe Disabling Mental Illness (SDMI)

This definition of severe disabling mental illness is based on diagnosis, duration of illness, and level of functioning. The criteria used by Montana are as follows:

“Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (a) or (b) or (c). The person must also meet the requirements of (d):

(a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital at least once; or

(b) has a DSM-IV diagnosis of
(i) schizophrenic disorder (295);
(ii) other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82);
(iii) mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, , 293.83);
(iv) amnestic disorder (294.0, 294.8);
(v) disorder due to a general medical condition (310.1); or
(vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;
(vii) anxiety disorder (300.01, 300.21, 300.22, 300.3) or

(c) has a DSM-IV diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least 6 months (or for an obviously predictable period over 6 months); and

(d) has ongoing functioning difficulties because of the mental illness for a period of at least 6 months (or for an obviously predictable period over 6 months), as indicated by at least two of the following:
(i) medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;
(ii) the person is unable to work in a full-time competitive situation because of mental illness;
(iii) the person has been determined to be disabled due to mental illness by the Social Security Administration;
(iv) the person maintains a living arrangement only with the ongoing supervision, is homeless, or is at risk of homelessness due to mental illness; or
(v) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes:
- increased symptoms of psychosis
- self-injury
- suicidal or homicidal intent, or
- psychiatric hospitalization.

Goal One: Adults with SDMI will have available to them comprehensive, accessible, community-based mental health services.

Indicator 1:	**The number of adults served by age, gender and race/ethnicity.**
Measure:	The number of adults served by age, gender and race/ethnicity.
Source of Information:	Enrollment/encounter data as provided by the mental health database.

Significance: The target population for state-funded mental health services is adults with SDMI that do not exceed 150% of federal poverty level.

FY 2003 Actual Numbers of Adults Served by the Public Mental Health System

Age	**Female**	**Male**	**Total**
18-20 year	564	380	944
21-64 year	8634	4762	13396
65-74 year	327	213	540
75+ year	588	240	828
Total	10113	5595	15708

	American Indian or Alaska Native		**Asian or Pacific Islander**		**Black or African American**		**White**		**Hispanic**	
Age	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*
18-20 years	70	40	1	1	4	2	469	330	20	7
21-64 years	904	399	25	11	35	28	7529	4264	141	60
65-74 years	14	16	1	0	2	0	307	191	3	6
75+ years	24	8	1	1	0	2	558	226	5	3
Total	1012	463	28	13	41	32	8863	5011	169	76

Actual FY 2004 Data

Age	**Female**	**Male**	**Total**
18-20 year	667	481	1148
21-64 year	8059	4166	12225
65-74 year	533	243	776
75+ year	1056	314	1370
Total	10315	5204	15519

	American Indian or Alaska Native		**Asian or Pacific Islander**		**Black or African American**		**White**		**Hispanic**	
Age	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*
18-20 years	110	54	2	2	4	5	522	396	18	20
21-64 years	936	374	21	8	40	26	6758	3526	181	79
65-74	47	26	3	1	2	2	477	209	2	3

years										
75+ years	41	13	1	1	0	3	1004	292	8	3
Total	1134	467	27	12	46	36	8761	4423	209	105

Goal Two: **Develop a formula for the prevalence of those persons with severe disabling mental illness.**

Indicator One: **Contract with a professional to develop Montana specific prevalence data for SDMI.**

Measure: Contract with entity.

Source of Information: Copy of contract.

Significance: Montana's definition for severe disabling mental illness is different from the federal definition of serious mental illness. All of the prevalence data provided for estimation is based on the federal definition. This will allow Montana to determine more accurately the prevalence and penetration rate.

Goal Three: **Provide ACT and DBT for appropriate target populations.**

Indicator One: **Provide ACT for those persons that meet criteria.**

Measure: Number of persons served.
Number of providers trained in providing ACT

Indicator Two: **Provide DBT for those persons that meet criteria.**

Measure: Number of persons served.
Number of programs trained in DBT.

Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
# Served for ACT	165	168	276	300	350
# Served for DBT	N/a	29	55	>55	>55
# Providers ACT	2	2	5	5	5
# Providers DBT	N/a	16	25	>25	>25

CRITERION 3: CHILDREN'S SERVICES

Not applicable

CRITERION 4: Targeted Services to Rural and Homeless Populations

The overall population density of Montana is 6.2 persons per square mile. Only three communities meet the U.S. Census Bureau definition of "urbanized area". Those communities are Billings (89,847), Missoula (57,053), and Great Falls (56,690). Using the Bureau of Health Care Delivery and Assistance definition of "frontier", 45 of Montana's 56 counties have a population density of fewer than six people per square mile. 32% of the state's population resides in one of these frontier counties.

For the purpose of planning mental health services, Montana is an entirely rural state and its mental health system is a rural mental health system. The extent to which this mental health system serves Montana's huge geographic area is impressive. The public mental health system provides professional mental health services in counties with as few as 1.66 people per square mile (Beaverhead County), and part-time professional mental health services in 26 counties with as few as 0.27 people per square mile (Garfield County).

The Eastern Montana Telemedicine Network began as a cooperative effort among healthcare providers in eastern Montana to research the potential of utilizing two-way interactive videoconferencing technology to provide medical and mental health consultations throughout the region. The Network has been operational since September 1993 and presently has twenty-one partner sites and can connect with compatible networks throughout the state, region and nation. Telemedicine ensures a continuum of mental health care throughout Eastern and Central Montana. Ninety-four percent of the patients seen over telemedicine were retained in their local community. 96% of the providers identified that consumers seen over telemedicine would have been referred out of the community if the technology had not been available. Mental health services provided include: medication review; follow up visits to monitor progress; discharge planning; individual and family therapy; emergency consultation; and employee assistance.

The Governor's Council on Homelessness has been selected as a participant in SOAR – SSI/SSDI Outreach, Access, and Recovery Technical Assistance Initiative. The Planning team will have a facilitated action planning session in December. The result will be a action plan that is designed to increase access to SSI and SSDI for homeless people with disabilities, including those with serious disabling mental illness and/or co-occurring disorders. Two persons will be attending the Train-the-Trainer session in December. These trainers will then conduct trainings for case managers and particularly PATH case managers. The project will be collecting and reporting on outcome data which will assess the effectiveness of Montana's plan to increase access to SSA disability benefits.

Three community mental health centers receive funding for PATH programs. They are:

1. South Central Mental Health Center receives a total of $113,5666 of which $85,174.50 is federal funds and $28,391.50 is general funds. Billings's community has three full time PATH workers with one being the supervisor.
2. Golden Triangle receives a total of $106,105 of which $79,278.75 is federal funds and $26,526.25 is general funds. Funds are provided to Great Falls and Helena communities for full time PATH case managers.

3. Western Montana Mental Health Center receives a total of $158,329 of which $118,746.75 is federal funds and $39,582.25 is general funds. The communities of Kalispell, Missoula and Butte have full time Path case managers.
4. Additional funds are withheld for training purposes which include:
    - Attendance at annual Mental Illness Conference
    - Training with the SSA office and quarterly meetings

The total number of persons served for FY 2004 was 1868. Of this number 987 were enrolled PATH clients. These are not enrolled mental health center clients.

Demographics of the enrolled PATH clients:

- Age – 46% are between 35-49 and 36% are between 18-34
- Gender – 65% are male and 35% female
- Race – 90% are Caucasians and 6% are American Indian
- Principal Diagnosis – 65% have a diagnosis of affective disorders and 16% have a diagnosis of schizophrenia or related diagnosis
- Co-Occurring Substance Abuse Disorders – 39% have a co-occurring substance abuse disorder
- Veteran Status – 70% are non-Veterans
- Housing Status – 51% are living in short term shelter, 22% are living in own or others dwelling and 10% are living outdoors
- Length of Time in Housing Status – 31% have been in current housing status two to 30 days, 19% are at 31 to 90 days, 3% are 91 days to 1 year and 2% are over 1 year

All enrolled PATH clients received outreach and case management services. 78% of the enrolled PATH clients received assistance in applying for housing, 35% received financial assistance in seeking housing, 78% received screening and diagnostic services, and 32% received referral to primary health services.

The mission of the Governor's Council on Homelessness is: *" To develop and implement strategies to prevent and reduce homelessness in Montana overall and to end chronic homelessness by 2014."* The Council has been in existence since June 2004. Most recently, the Council has begun looking at strategies designed to impact this complex issue as a whole. These strategies include creating a single definition of homelessness in Montana as well as creating common standards for meeting the needs of the homeless persons, including prioritizing them and agreeing not to release anyone into homelessness. As Montana's planning body for formulating and affecting change in the policies and practices that play a role in homelessness, the Department and PATH program are actively involved in the Council and workgroup activities.

The Council has received the SOAR – SSI/SSDI Outreach, Access and Recovery Technical Assistance. A team of thirty will be identified to develop an action plan that will support the goal of enhancing access to SSI/SSDI for persons with serious mental illness and homeless. A minimum of two persons will attend the Train-the-Trainers, which will increase the capacity to provide ongoing statewide training and technical assistance to the case managers and others assisting the homeless applicants for SSI/SSDI.

The PATH case managers will be using the Recovery Markers web based measures. It is hoped that we will be able to better track the results of case management for the homeless population as they PATH case management services and then the mainstream mental health services. The measures that will be tracked quarterly are: living status; employment/education; symptom interference; stages of change for alcohol and drug use; and level of use of alcohol and/or drug use.

Goal 1: Individuals who are homeless and have a mental illness will have access to mental health services.

Indicator One: **50% of those persons outreached will be PATH enrolled.**

Measure: Numerator: The number of persons enrolled in PATH services.
Denominator: The number of persons who are contacted by PATH case managers and have a serious mental illness.

Source of Information: PATH annual report.

Significance: To move the homeless with serious mental illness into services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	50%	45%	50%	>50%	>50%
Numerator	862	987	1100	>1100	>1100
Denominator	1707	2220	2220	2220	2220

Indicator Two**:** **Case Managers will report on living status of persons with serious disabling mental illness.**

Measure: Living status of persons receiving case management.

Source of Information: Strengths Based Recovery Marker

Significance: Housing is one of the major keys towards recovery.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal year	FY 2003 Actual	FY2004 Actual	FY2005 Target	FY2006 Target	FY2007 Target
# Homeless	Not reported	Not reported	<5%	<5%	<5%
# Group Home/	Not reported	Not reported	>15%	>15%	>15%

Congregated living					
# SRO	Not reported	Not reported	<5%	<5%	<5%
# Subsidized Independent Living	Not reported	Not reported	>55%	>55%	>55%
# Unsubsidized Independent Living	Not reported	Not reported	<20%	<20%	<20%

Goal 2: **Mental Health Services Bureau will participate in the SSA and Homelessness Initiative**

Indicator One: **Select persons to attend training on documentation of SSI/SSDI applications.**

Measure: The number of persons receiving training.

Source of Information: Attendance at training.

Significance: This initiative will enable persons to receive benefits, which translate to medication and housing.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	N/A	N/A	5	15

Indicator Two: **Attend the SSA Training of Trainers**

Measure: Attendance at training

Source of Information: Documentation of training

Significance: The trainer of trainers would begin to develop capacity for ongoing education on documentation of SSI/SSDI applications.

Goal Three: **Ensure housing is available to persons with serious disabling mental illness.**

Indicator One: **Participate in the Governor's Council on Homelessness.**

Measure: Attendance in meetings and activities

Indicator Two: **Develop housing projects in communities with PATH**

Measure: Plans for housing development

Goal Four: Ensure training is made available to programs serving rural counties.

Indicator One: Rural programs participate in the training for DBT, Co-Occurring and Strengths Based Case Management

Measure: Attendance at trainings

Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
# Programs trained in DBT	N/a	0	2	4	6
# Programs trained in Co-Occurring	N/a	4	6	>6	>6
# Programs trained in Case Management	N/a	N/a	4	>6	>6

CRITERION 5: Management Systems

Staffing

Efforts to recruit and retain qualified professionals to work in Montana's public mental health system continue. A practicum is available for nursing students at Montana State Hospital as well as internships and field placements for students in psychology, counseling, and recreation therapy. Additionally, licensed mental health centers provide the opportunity for students who have completed the academic requirements for licensure to work under supervision for the required period of time before becoming eligible for the licensing examination. Taking advantage of loan forgiveness incentives associated with working in Health Professional Shortage Areas also assists with recruitment. The results of the loan forgiveness for psychiatrists have been poor. The Division requested a rate increase for the psychiatrists the past 2005 Legislative session. This was the only provider rate increase requested by the Division.

Presently, six persons manage the mental health community services for the state of Montana. The AMDD is the only Division in this Department that did not have a community presence. This will change for FY 2006 and 2007. The Mental Health Services Bureau will have three field staff positions available in FY 2006. In FY 2007 the Bureau will receive two additional field staff positions. The field staff will help further the Service Area Authority efforts, work to develop needed community crisis services, and provide a direct contact for community persons.

Training of Consumers and Family members

Montana invests considerable resources to support the training opportunities for consumers, family members, providers, and other stakeholders. The Department will continue it's funding for education programs provided by NAMI for consumers, family members, and providers. AMDD provides scholarships for consumers to attend the annual Mental Illness conference. Over 150 consumers attend the Mental Illness Conference annually.

For FY 2004 the Peer-to-Peer program was offered in Missoula, Billings and twice in Helena. Twenty-two persons completed the training in the three communities. NAMI has ten consumer trainers for the Peer-to Peer program.

The Family to Family Education program has been taught in Kalispell, Billings, Helena, Bozeman, Polson, and Missoula during FY 2004 for a total of eight twelve week classes. One hundred twenty-one family members have completed the course. Since 1997, close to 1000 people have been educated through the Family-to-Family Education course. Four teacher trainings have been held since the original training where sixteen teachers were trained in 1997. Forty-one additional teachers have been trained in seven communities. NAMI provides support groups and facilitators are located in Billings, Butte, Bozeman, Hamilton, Helena, Lewistown, and Missoula.

The NAMI "In Our Own Voice" has made fifteen presentations and reached 303 persons for calendar year 2004. "In Our Own Voice" has 26 trainers in ten communities.

NAMI's Provider Education program was provided at the Montana State Hospital with 23 participants and Yellowstone Treatment Center with 21 participants. NAMI anticipates providing two trainings in FY 2005 and training two more teams.

Training of Providers

The Division has a three-year contract with Drs. Ken Minkoff and Chris Cline. We are in our second year of the contract. The mental health and chemical dependency funds are pooled together to provide co-occurring training to the providers. Training has been provided in October 2004 (54 attendees), January 2005 (61 attendees), and in June (71 attendees). The training identified for the next two years will include: training psychiatrists regarding co-occurring issues; providing a minimum of two a year train-the-trainer for program staff; and training the executive directors of each program.

The Division will be providing training on co-occurring screening tools for the chemical dependency and mental health programs. The state will be developing the capacity of programs to provide training on the integration of co-occurring and other issues as we move toward co-occurring capable and enhancement.

Ten persons will be attending the Co-Occurring Policy Academy in September. This will help Montana move to the next level of administrative and clinical integration of co-occurring.

The AMDD provided training in Dialectical Behavior Therapy (DBT) in November (76 attendees), April (61 attendees), and May (145 attendees). In November the second training for

the teams trained in April will be conducted. The focus for the next two years will be to develop outcome measures for this program and provide ongoing support to the existing teams.

Training on Employment and the Strength's Based Assessment will be provided in September. This will be a combination of vocational rehabilitation counselors and mental health supportive employment specialists. It is hoped that the outcome of the training will be a better working relationship between the two agencies and ultimately a better outcome for the consumers.

A Trainer of Trainers for strength based case management will be provided in the winter of 2006. It is important that Montana build the capacity to provide ongoing training to case managers, rather than rely on out of state consultants. In addition, we will be purchasing video materials to be available to all programs for ongoing education of the case managers.

Crisis Services and Training

Helena sent at team to Memphis for the 40-hour Community Intervention Team (CIT) training. The team will begin providing training to the law enforcement of Helena in the fall of 2005. The law enforcement agencies in Helena have provided a great deal of support for implementation of CIT in the community. The biggest obstacle for full implementation has been the lack of crisis services beyond the emergency room of the community hospital. Crisis services in Helena should be available in the fall.

The Billings community identified crisis services for persons with co-occurring disorders as a community priority. The Deaconess Hospital, Deering Clinic, St. Vincent Hospital and South Central Mental Health Center have created a separate corporation to address this issue. The crisis center will be opening fall 2005. The facility will have access to psychiatrists, physicians, nurses, therapists and case managers. Each agency will be providing staff for the facility.

The communities of Glasgow and Glendive are considering the CIT program for their individual communities. Again the biggest obstacle will be the availability of crisis services. The Glendive Community Hospital has a four bed psychiatric unit but is under utilized. The psychiatrist is the person with admitting privileges to the unit. Bozeman community has a crisis house available in their community. Communities have had to develop crisis services out of necessity.

Training and certification to law enforcement in Montana will be funded through the Department of Justice and Attorney General's office. The Montana Law Enforcement Academy is committed to providing training through regional training, in mental health crisis intervention. The Attorney General is considering requiring each new law enforcement cadet to receive more than the two-hour training they currently receive on mental health and substance abuse emergencies.

AMDD will be conducting a study of the entire mental health system regarding community mental health crisis services. The AMDD Administrator has assured the legislature the two field staff for FY 2006 and one field staff person in FY 2007 will plan for and implement development of crisis services. The AMDD will be working closely with the SAAs, LACs, Council, county and city officials, providers and other stakeholders to develop a plan that can be

taken to the 2007 Legislature. AMDD's plan needs to be completed by late summer of 2006 for inclusion in the Governor's budget for 2007 Legislative session.

The Children, Families, Health and Human Services Interim Committee have determined one of their activities will be the study of community mental health crisis services. The study will include the following: where the responsibility lies or should lie for providing crisis services in the community; planning and development of services; what and how services should be provided at the community level; what populations should be served; how to encourage cooperation between and within communities in the planning, development and provision of services; and the funding and cost consideration of crisis services. The Committee's study and recommendations will be completed by September 15, 2006 for possible submission to the 60th Legislature.

Consumer and Family Member Participation in Planning and Decision-making

Montana will continue its long-standing commitment to collaboration with consumers and family members in the development of the public mental health system. This is evident in the Mental Health Oversight Advisory Council, Local Advisory Committees, Service Area Authorities, and ongoing relationship with the Mental Health Ombudsman.

The SAA is required to have 51% consumer and family member representation on each of the three SAA boards. Consumers and family members are encouraged to participate on the decision making at the local level. The LAC each determines the allocation of community mental health resources.

It is exciting to witness consumers participating in the decisions necessary to determine the allocation of mental health services at the local, regional and state levels.

Data Infrastructure Grant

AMDD has the Data Infrastructure Grant, the purpose of which is developing a data infrastructure in each of the states and territories. This allows for data available at the national level that aids states in planning efforts and allows the federal government to demonstrate effectiveness of services and funding streams. The data available is the Uniform Reporting System with common definitions and standards. The Departments of Public Health and Human Services and Justice have entered into a data sharing agreement. The Department will be receiving arrest records from the Department of Justice.

The AMDD will have a Behavioral Health Analyst position by fall 2005. The analyst position will be reviewing data currently received and developing reports for all key stakeholders for trend analysis and outcome measures.

Management of Aystem

The Mental Health Services Bureau has a bureau chief, quality assurance manager, program manager, regional planner, and two human services position. In addition, the bureau receives

support from the administrator's office. Six full time staff has managed community mental health services. The bureau will be receiving three field staff in FY 2006 and an additional two field staff in FY 2007.

First Health provides two contracted adult coordinators. These coordinators work closely with the state hospital and providers to ensure appropriate community placement.

The Department has recently entered into an agreement with Comprehensive Neuroscience (CNS) to improve prescribing practices for mental health prescription drugs. CNS has analyzed the Medicaid claims data and compared that data against national best practices, and has identified a list of prescribers that are "outliers" – meaning they are not conforming to best practice. CNS, in cooperation with the drug utilization review board, will begin educational efforts with the first group of outliers. This has proven to save thousands of dollars in prescribing practices in other states.

Use of Block Grant Funds

The CMHS Mental Health Block Grant allocation for Montana is estimated to be $1,258,971. In FY2005 Montana will use all block grant funds for services for adults with severe disabling mental illness. The program activities supported by block grant funds are part of the Mental Health Services Plan and all funds will be used to purchase community-based services.

The funds available for the adult mental health system in FY 2006 are $49,381,172. Mental Health Services include ACT, MHSP, Intensive Community Based Psychiatric Rehabilitation, Intergovernmental transfers, mental health block grant and Medicaid. FY 2007 includes the Home and Community Based Waiver. The Mental Health Administration includes funding for the Helena staff and the new field staff.

The administration budget is funded with general fund and Medicaid funds. The difference between the FY 2006 and FY 2007 is the biennial appropriation for MHSP of $6.5 million. Biennial appropriations are shown in the first year of the biennium, which is FY 2006. Whatever is not spent in FY 2006 will be carried over to FY 2007.

Below are the tables of resources allocated for FY 2006 and FY 2007.

Funds	FY 2003 Actual	FY 2004 Actual	FY 2005 Estimated	FY 2006 Budgeted	FY 2007 Budgeted
Mental Health Services	33,024,681	35,572,491	40,128,025	47,774,634	44,174,325
Mental Health Administration	1,275,655	1,868,887	1,987,802	1,606,538	1,762,965
TOTAL	34,300,336	37,441,378	42,115,827	49,381,172	45,937,290

Federal block grant and general funds are used to contract with the mental health centers to provide community services to those persons that qualify for MHSP. General funds are used for the pharmacy emergency funds for each community mental health center. The table below is

the contracted funds for FY 2006. The FY 2007 funds will be dependent on the HIFA waiver. If the waiver is not successful, the contracts will be the same as FY 2006. If the waiver is successful, $1,008,901 will be included in the contracts for services to adults eligible for the Mental Health Services Plan. The remaining, $240,000, will be made available to SAAs. Each SAA will develop a proposal for $80,000 to meet identified needs.

Funds	**MHSP**	**Pharmacy**
Eastern Montana MHC	461,544	6,829
Golden Triangle MHC	722,876	16,608
South Central MHC	747,801	17,543
Western Montana MHC	1,500,925	34,020
TOTAL	3,433,146	75,000

Goal One: Increase the number of psychiatrists in Montana

Indicator One: **Track the number of psychiatrists providing services to the SDMI population.**

Measure: Number of psychiatrists practicing.

Source of Information: The ACS report of providers available in Montana.
Significance: This will determine if the provider rate increase was effective. Provide better psychiatric access for the SDMI population.

Indicator Two: Track the number of individuals receiving psychiatric services.

Measure: To determine if the increase in psychiatrists will increase access to services.

Source of Information: Claims based data system

Significance: This will determine if the provider rate increase was effective. Provide better psychiatric access for the SDMI population.

	(1)	(2)	(3)
Indicator	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Number of Psychiatrists	46	>46	>46
Number of Individuals	2142	>2142	>2142

Goal Two: Develop a plan for crisis services

Indicator One: **AMDD will work closely with the Mental Health Oversight Advisory Council, SAAs, and LACs on crisis services.**

Measure: Strategy for crisis services in Montana

Source of Information: Summaries from Council meetings

Significance: Access to crisis services is a priority for the Council.

Indicator Two: **Evaluate current crisis services**

Measure: Report on services available

Source of Information: Written report

Significance: Determine the availability of crisis services.

Indicator Three: **Plan will be developed for future crisis services**

Measure: Plan made available to Council, Interim Committee and AMDD

Source of Information: Written report

Significance: Access to crisis services is a priority for the Department, Legislature and the MHOAC.

Goal Three: Support and enable persons with severe disabling mental illness and family member participation.

Indicator One: **Maintain a minimum of 51% persons with severe disabling mental illness and family membership on Mental Health Oversight Advisory Council.**

Measure: Proportion of appointed membership that is identified as a consumer of mental health services or a family member of a consumer of mental health services.

Source of Information: Advisory Council roster of membership

Significance: Consumers and family members need to be in positions of advocacy and oversight of mental health services in Montana.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	50%	40%	50%	51%	51%

Indicator Two: **Support the Local Advisory Councils (LAC) across the state.**

Measure: Meetings attended by the field staff and regional planner

Source of Information: Summaries of reports from LACs, field staff and regional planner

Significance: The communities are in a better position to determine the need for services in their area.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	Not Reported	Not Reported	15	>15	>15

Indicator Three: **Support Service Area Authorities (SAA) across the state.**

Measure: Attendance at SAA leadership and Congress meetings

Source of Information: Attendance sheets at meetings

Significance: The SAAs will be the decision makers of needed services in their areas. The state needs to ensure the successfulness of the SAAs.

Goal Four: Support education for persons with severe disabling mental illness, family members, and providers

Indicator One: **Contract with NAMI to provide the following training:**

a) Family to Family education program offered in a minimum of three communities in Montana
b) Support Group Facilitator training
c) "In Our Own Voice" Living with Mental Illness offered in three communities
d) Provider Education Course offered in two communities
e) Peer to Peer Recovery Course offered in three communities

Measure: a) Courses and training provided
b) Number attending courses

Source of Information: Report from NAMI

Significance: Education is the key to understanding serious mental illness and how it affects the way people think, feel and act. Providing education about severe mental illness will support the recovery process for people with psychiatric disabilities through improved understanding, and reduction of stigma and prejudice.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal year	FY 2003 Actual	FY2004 Actual	FY2005 Target	FY2006 Target	FY2007 Target
Number of Family to Family	3	>3	>3	>3	>3
Number of Support Group Facilitator	1	>1	>1	>1	>1
Number of "In Our Own Voice"	1	1	3	3	3
Provider Education	2	2	2	2	2
Peer to Peer	1	3	>3	>3	>3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal year	FY 2003 Actual	FY2004 Actual	FY2005 Target	FY2006 Target	FY2007 Target
Participants of Family to Family	102	>3	>3	>3	>3
Participants of Support Group Facilitator	Not reported	Baseline	>Baseline	>Baseline	>Baseline
Participants of "In Our Own Voice"	25	50	>50	>50	>50
Participants of Provider Education	30	30	>30	>30	>30
Participants of Peer to Peer	Not reported	Baseline	>Baseline	>Baseline	>Baseline

Goal Five: **Provide training to community mental health providers and state approved alcohol and drug programs.**

Indicator One: **Develop a Trainer of Trainers model for case management**

Measure: Persons attending Training of Trainers for case management.

Source of Information: Attendance and letters of invitation

Significance: To build capacity within the state.

Indicator Two: **Develop statewide training plan in co-occurring**

Measure: Training plan developed and implemented.

Source of Information: Written plan

Significance: Provide a roadmap for the co-occurring initiative and will allow the state and stakeholders to evaluate the initiative.

Indicator Three: **Training provided:**
1. **Training of psychiatrists and advanced practitioners**
2. **Provider training**
3. **Policy Academy attended**

Measure: Training provided and numbers attending

Source of Information: Attendance sheets, advertisement and written plan.

Significance: The co-occurring initiative needs to be weaved throughout the systems in Montana.

Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Targeted	FY 2006 Targeted	FY 2007 Targeted
Psychiatrist Training	Not Reported	Not Reported	Not Reported	20	20
Provider Training	Not Reported	Not Reported	75	100	125
T of T Case Management	Not Reported	Not Reported	Not Reported	20	10

Goal Six: Collect and report on data from the recovery markers.

Indicator One: **Have programs begin submitting data in fall of 2005**.

Measure: Date submitted and reports generated

Source of information: The web access program

Significance: Providers will utilize the outcomes to determine the individual needs of consumers. Supervisors will be better equipped to train case managers.

Indicator Two:	**Train supervisors on the usefulness of the recovery marker data.**
Measure:	Training held and number attended
Source of Information:	Attendance sheets
Significance:	This moves the mental health system to a recovery based and person centered system.
Indicator Three:	**Reports developed for AMDD and the programs.**
Measure:	Developed reports
Source of Information:	Reports
Significance:	The reports will help the mental health system keep outcomes in the fore front.

Goal Seven: Allocate Community Mental Health Block Grant for persons with severe disabling mental illness.

Indicator One:	**Block Grant funds of $1,248,901 will be included in the contracts for services to adults eligible for the Mental Health Services Plan in FY 2006.**
Indicator Two:	**In FY 2007, $1,008,901 will be included in the contracts for services to adults eligible for the Mental Health Services Plan. The remaining, $240,000, will be made available to SAAs. Each SAA will develop a proposal for $80,000 to meet identified needs.**